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No. 14-7955

IN THE

Supreme Court of the United States

RICHARD E. GLOSSIP, ET AL.,
Petitioners,

v.

KEVIN J. GROSS, ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

REPLY BRIEF FOR PETITIONERS

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REPLY BRIEF FOR PETITIONERS

Oklahoma may not execute petitioners with a paralytic drug and potassium chloride unless it can reliably prevent petitioners from feeling the suffocation and pain that those drugs concededly cause. Midazolam cannot serve that purpose. Respondents do not point to any scientific or medical consensus that midazolam alone reliably prevents a person from experiencing significant pain. Absent such consensus, lethal injection using a paralytic and potassium chloride poses a risk of harm that is objectively intolerable.

Respondents also urge the Court not to reach the merits. But the question whether midazolam, a drug that is "not anesthesia," poses an objectively intolerable risk of harm under the Eighth Amendment is an important question of law that this Court can and should resolve now. Despite citing two dozen sources not mentioned in the proceedings before the district court, respondents fail to identify a single study establishing that large doses of midazolam reliably cause comalike unconsciousness. Respondents also offer no reason why the Constitution requires a prisoner to cure the defects in a state's lethal injection protocol or accept an unconstitutionally cruel death.

I. THE PETITION SHOULD NOT BE DISMISSED.

Whether the Eighth Amendment permits states to administer constitutionally intolerable drugs without reliable anesthesia is a question of law that "should be[] settled by this Court." Sup. Ct. R. 10(c). That question has been fully briefed and is ripe for this Court's review. And it should be decided now, before

petitioners are subjected to a constitutionally unacceptable execution.[1]

1. In arguing that the petition was improvidently granted, respondents characterize "[p]etitioners' primary contention [as one asserting] that the district court committed clear error." Resp. Br. 38. But petitioners' primary contention is that, on the undisputed facts alone, relying on an unquantifiably riskier drug that is "not anesthesia," J.A. 78–79, to protect a prisoner against the grave harms inflicted by the second and third drugs poses the sort of "substantial" and "objectively intolerable" risks the Eighth Amendment forbids. *Baze* v. *Rees*, 553 U.S. 35, 50 (2008). Because the district court misapplied Eighth Amendment jurisprudence to the undisputed facts—which show that midazolam poses "greater risks" of pain than any other first drug previously used in a three-drug protocol, J.A. 78–79—this Court need not reach the issue of the district court's factual error. But in all events, on a question of constitutional importance—and one that district courts often decide under intense time pressure—clear error is no obstacle to this Court's review. See, *e.g.*, *Miller* v. *Fenton*, 474 U.S. 104, 116

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[1] Respondents argue that Oklahoma "extensively revamped" its execution facility and its procedures, Resp. Br. 16–17, and that this will prevent any further episodes like the gruesome execution of Clayton Lockett because a "deficiency in a drug protocol can be obviated by robust procedural safeguards," Resp. Br. 55–56. But respondents identify no procedural safeguard that cures midazolam's fundamental pharmacological inability to be anesthesia, nor do they address or even acknowledge that the use of the paralytic as the second drug will likely mask any pain caused by the revamped protocol. As an *amicus* brief filed on behalf of former state attorneys general points out, Oklahoma's recent revamping will not prevent another execution like Lockett's from occurring again. *See* Former State Attorneys General *Amicus* Br. 14–17.

(1985); *Bose Corp.* v. *Consumers Union of U.S., Inc.*, 466 U.S. 485, 510–11 (1984). That is especially the case where, as here, the errors that occurred were "obvious and exceptional." *Comcast Corp.* v. *Behrend*, 133 S. Ct. 1426, 1433 n.5 (2013) (rejecting contention that conclusions drawn from an expert's views were themselves "questions of fact" subject to clear error review and that petition was improvidently granted, explaining that, "even if it were a question of fact, [the conclusions were] . 'obvious[ly] and exceptional[ly]' erroneous").

2. The issue of whether *Baze* erected a higher standard for obtaining a stay of execution than that set forth in *Hill* v. *McDonough*, 547 U.S. 573, 584 (2006), and *Barefoot* v. *Estelle*, 463 U.S. 880, 895–96 (1983), *superseded on other grounds by statute*, 28 U.S.C. § 2253, is an important and recurring issue of law that drove the decision below, see J.A. 130, and one that only this Court can definitively address. The same is true regarding the question of whether prisoners must bear the burden of proposing an alternative to an unconstitutional method of execution. Although these issues were "not outcome-determinative" here, Resp. Br. 39 (quoting J.A. 130), they would necessarily be reached if the law were correctly applied to the facts and, given the gravity of capital punishment and the abbreviated review periods that courts face, warrant this Court's review.

II. MIDAZOLAM CANNOT RELIABLY PREVENT PRISONERS FROM EXPERIENCING THE SUFFOCATION AND PAIN OF A PARALYTIC AND POTASSIUM CHLORIDE.

A. A Benzodiazepine That Is "Not Anesthesia" Cannot Serve As The Sole Anesthetic In A Three-Drug Lethal Injection.

Petitioners present a threshold question of law that this Court can review de novo without addressing the district court's clear error: whether lethal injection using constitutionally intolerable drugs becomes permissible under the Eighth Amendment if the prisoner is first injected with midazolam. Two undisputed facts alone warrant reversal here: (1) the district court found that midazolam is not anesthesia and poses an unquantifiably greater risk of harm than the barbiturates previously used for this purpose, and (2) there is no medical consensus that midazolam reliably causes and maintains unconsciousness during painful procedures.

1. The district court erred as a matter of law by holding that the Eighth Amendment's prohibition against "substantial" or "objectively intolerable" risks of serious harm can be satisfied by a drug whose risk is unquantifiably "greater" than that presented by the constitutionally acceptable use of barbiturates. The district court found that "as opposed to pentobarbital or sodium thiopental" midazolam plainly presented an "added element of risk of pain." J.A. 79. The court was unable to estimate the magnitude of that danger, finding that "nobody knows" "[h]ow much greater that risk is." *Id.*

Respondents rely heavily on the district court's finding that a 500 mg dose of midazolam would, through a "phenomenon" that is "not anesthesia,"

J.A. 78, make it a "virtual certainty" or "highly likely" that a person would remain insensate throughout a painful execution, J.A. 125; see Resp. Br. 33–34, 42. A drug that carries an unquantifiably "greater" risk of not causing deep comalike unconsciousness cannot, at the same time, also be "virtually certain" to have that effect. It is objectively intolerable to rely on an unquantifiably risky drug that is "not anesthesia" as the sole anesthetic in an otherwise unconstitutionally painful lethal injection. *Baze*, 553 U.S. at 50, 53. Respondents do not and cannot reconcile the district court's internally inconsistent findings, and this inconsistency alone warrants reversal.

2. In *Baze*, there was a medical consensus that sodium thiopental produces "'deep, comalike unconsciousness,'" Pet. Br. 30 (quoting *Baze*, 553 U.S. at 44); here, there is no corresponding medical consensus. Indeed, respondents' expert agreed that he would advise a physician *not* to use midazolam as the sole drug in a painful procedure, J.A. 333, that midazolam is used by itself only in "quick procedures that are not necessarily terribly invasive," and that "even for something like a colonoscopy you would see it used *in combination with a narcotic*." J.A. 307 (emphasis added). Respondents now cite nearly two dozen extra record sources in an effort to change the record, but none establishes a medical consensus that large doses of midazolam will reliably prevent a person from feeling suffocation and pain. That lack of a consensus alone establishes an "objectively intolerable" risk of harm.

Respondents first try to create the appearance of a consensus by claiming that midazolam is used in a range of medical procedures such as setting a femoral IV, dental extraction, or intubation. See Resp. Br. 5–7, 24–25, 42. Respondents are unable, however, to

point to a single source or record evidence establishing a medical consensus that endorses using midazolam as the *sole* agent in seriously painful procedures.[2] Not only would such use be inconsistent with the district court's own finding,[3] but respondents' own sources undermine any such claim. For example, although respondents cite to the landmark study regarding midazolam, they appear to misunderstand the study, by relying upon it for the point that "'midazolam may be used intravenously for the induction of anesthesia' . . . . as an alternative to sodium thiopental . . . ." Resp. Br. 5 (quoting J. G. Reves et al., *Midazolam: Pharmacology and Uses*, 62 Anesthesiology 310, 312, 317–18, 324 (1985)). But the induction of anesthesia refers to quickly sedating a person *before* administering other, potentially more noxious or slower-acting drugs; it is very different than *maintaining* anesthesia. On that point, respondents ignored the key sentence in that same study that follows the one they selectively cite: "[M]idazolam *can*-

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[2] Respondents' contention that intubation is a "'10 out of 10' on the pain scale," Resp. Br 7 & n.2, is unsupported by the source they reference, which does not discuss pain during intubation, and instead references the experiences of individuals who had been on mechanical ventilation for more than 48 hours. *See* Armando J. Rotondi et al., *Patients' Recollections of Stressful Experiences While Receiving Prolonged Mechanical Ventilation in an Intensive Care Unit*, 30 Critical Care Med. 746, 748 (2002). Respondents also cite Dean Evans's testimony that he has heard of midazolam being used to "induce a coma" in "brain-injury patients . . on a continuous infusion," Tr. of Prelim. Inj. Hr'g at 661–62, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17–19, 2014) [hereinafter Tr.], but cannot support what Dean Evans has heard with any citation to scientific literature.

[3] The district court found that midazolam is approved for "*induction* of general anesthesia to be used *before administration of other anesthetic agents*" and is "not an analgesic." J.A. 76 (emphasis added).

not be used alone, however, to maintain adequate anesthesia . . . ." Reves, *supra*, at 312, 317–18 (emphasis added). This source alone illustrates that there is no consensus that midazolam can reliably be used as a sole anesthetic for a painful procedure.

Respondents also assert that the FDA label for midazolam shows that a "'coma' can result" from a large dose. Resp. Br. 5, 42. But the FDA label states only that "[t]he manifestations of midazolam overdosage reported are similar to those observed with other benzodiazepines, including sedation, somnolence, confusion, impaired coordination, diminished reflexes, coma and untoward effects on vital signs." 10th Cir. Supp. Vol. XXII, *Warner* v. *Gross*, No. 14-6244 (10th Cir. Dec. 29, 2014) (Ex. 2 to Report of Larry Sasich, PharmD, Pltfs' Ex. 77) [hereinafter Midazolam Label]. This statement means only that midazolam is associated with some adverse events involving coma; it is not a finding of the FDA that midazolam reliably causes a coma, and any such conclusion is belied by other statements on the label that respondents fail to cite. See, *infra* pp. 13–14.

Respondents try to get around this lack of consensus by arguing that, even if midazolam cannot reliably be used as the sole agent for a painful procedure, it can at least render a person "substantially unaware" of pain, "regardless of the exact depth of consciousness." Resp. Br. 44. Respondents do not explain, however, how the State would measure "substantial unawareness"—indeed, there is no support whatsoever in the record for that term. Nor do they show a medical consensus that midazolam would reliably cause and maintain "substantial unawareness" of suffocation and significant pain.

Respondents also fail to explain how such "substantial unawareness" can be squared with midazolam's

undisputed lack of an analgesic effect. Though respondents claim analgesia is not "relevant to the Eighth Amendment analysis," Resp. Br. 50, the lack of an analgesic effect means that midazolam's ability to prevent pain depends entirely on how reliably midazolam can keep a person unconscious. Once a prisoner is jolted out of unconsciousness, he experiences unblunted, constitutionally unacceptable pain—precisely as Oklahoma's execution of Clayton Lockett illustrated.[4] But unless there are appropriate measures in place to constantly monitor anesthetic depth,[5] any state of awareness more conscious than the "deep, comalike" unconsciousness endorsed in *Baze*—*i.e.*, such as being merely "substantially unaware"—would create an objectively intolerable risk of experiencing substantial pain.

Respondents' argument thus amounts to this: the State wishes to conduct lethal injections using concededly painful, constitutionally intolerable drugs, by first administering a drug that has no analgesic ef-

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[4] Respondents argue that Lockett awoke only because "[e]nough midazolam made it into Lockett's bloodstream to cause temporary induction of unconsciousness, but not enough to maintain an adequate level of unconsciousness." Resp. Br. 14. But the "concentration of midazolam located in Lockett's blood," even after death, "was [still] greater than . . . necessary to render an average person unconscious." J.A. 397. Lockett's waking after 10 minutes had nothing to do with the passage of time, and everything to do with midazolam's inability to reliably maintain unconsciousness through pain. Neither the Lockett execution, the sources respondents cite (*see* Resp. Br. 44 n.18), nor any record evidence supports respondents' assertion that midazolam reliably blunts pain. *See* J.A. 222, 241, 243, 287.

[5] In *Baze*, the concern for careful monitoring and maintenance of anesthetic depth was "obviate[d]" by the undisputed fact that a proper dose of thiopental would reliably ensure a barbiturate coma. 553 U.S. at 59.

fect, is "not anesthesia," but will cause a state of "substantial unawareness" that no text or expert has identified, and that the State has no tools or personnel to measure, monitor, or maintain. This approach poses an objectively intolerable risk of harm, and violates the Eighth Amendment. The decision of the court of appeals should therefore be reversed.

B. The District Court's Findings About Midazolam Were Clearly Erroneous.

The district court committed clear error in finding that a 500 mg dose of midazolam would cause a coma or death. This error independently requires reversal. A lethal-injection protocol using a paralytic and potassium chloride must first reliably place a prisoner into a comalike state for there to be reasonable confidence that the constitutionally intolerable suffocation and pain of those drugs will not stimulate the prisoner into consciousness. Because midazolam is not an analgesic, a prisoner who is jolted into consciousness will feel the full force of the second and third drugs. The district court's finding that midazolam will prevent such a return to consciousness was clearly erroneous.

1. The district court found "that whatever the ceiling effect of midazolam may be with respect to anesthesia, which takes effect at the spinal cord level, there is no ceiling effect with respect to the ability of a 500 milligram dose of midazolam to effectively paralyze the brain." J.A. 78. This explanation of midazolam's ceiling effect is not supported by record evidence, scientific scholarship, or even basic logic. The very meaning of a "ceiling effect" is that, after a certain point, additional doses cease to have any further effect. See Pet. Br. 14–17. If, as all experts testified, midazolam does have a ceiling effect, then Oklahoma's plan to cause a coma by giving a massive dose of

midazolam necessarily falls apart. Here, overwhelming record evidence establishes that midazolam has a ceiling effect that precludes its use as a reliable, sole anesthetic.

First, respondents assert that the ceiling effect only "potential[ly]" or "hypothe[tically]" exists. Resp. Br. 46, 53.[6] But all experts below—including Dean Evans—confirmed that midazolam has a ceiling effect, J.A. 206, 331; Tr. 343; Tr. 664, and the district court found its existence as a fact, J.A. 78.

Second, respondents suggest that the medical literature on midazolam's ceiling effect is "sparse." Resp. Br. 46. But, as the *amicus* brief of sixteen pharmacology professors underscores, a ceiling effect is a fundamental, inherent, and ineluctable property shared by all benzodiazepines. See J.A. 265, 209; Sixteen Professors of Pharmacology *Amicus* Br. 19.[7] Thus, Dean Evans's suggestion that midazolam would have

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[6] Unable to point to any scholarship or record testimony undermining midazolam's ceiling effect, respondents resort to expert testimony from other cases. *See* Resp. Br. 53–54. But the experts in those cases did not testify that midazolam's ceiling effect did not exist, nor did either anesthesiologist testify that he uses midazolam as the sole agent in painful surgical procedures. *See* Transcript of Feb. 11, 2014 Evidentiary Hearing at 233–34, *State* v. *Howell*, No. 1992-cf-22 (Jefferson Cnty., Fla. Cir. Ct. Feb. 13, 2014) (Dr. Dershwitz testifying only that he used midazolam to *induce* anesthesia); Ex. C of Verified Compl. at 112, *Muhammad* v. *Crews*, No. 3:13-cv-1587 (M.D. Fla. Dec. 23, 2013), ECF No. 1–3 (Dr. Heath noting only that he uses midazolam for procedures that are "somewhat uncomfortable").

[7] Respondents cite two of the textbooks upon which the *amicus* brief relies. Resp. Br. 4 (citing Dennis S. Charney et al., *The Pharmacological Basis of Therapeutics* 401 (11th ed. 2006); George Brenner & Craig Stevens, *Pharmacology* 192 (4th ed. 2013)).

a "linear effect" was nothing more than wishful thinking. J.A. 332.[8]

Third, respondents have no defense for Dean Evans's explanation that midazolam's ceiling effect is something affecting only the "spinal column." J.A. 331. Nor could they ever provide such a defense. That explanation lacks any basis in science. See *Gen. Elec. Co.* v. *Joiner*, 522 U.S. 136, 146 (1997) ("[N]othing . . requires a district court to admit opinion evidence that is connected to existing data only by the *ipse dixit* of the expert."). Moreover, and dispositively, this conclusion is undermined by Dean Evans's own testimony that "there are GABA receptors along the entire length of the central nervous system, *not just in the spinal cord*, and that midazolam binds to those GABA receptors . ." Resp. Br. 28 (emphasis added) (citing J.A. 314). Given that midazolam's mechanism of action requires pairing with GABA, there is no way that the ceiling effect—which is purely a function of exhausting the available GABA—could be limited to only one part of the central nervous system. Respondents cannot account for Dean Evans's misunderstanding of these basic facts on the grounds that he was simply using a "shorthand way" of describing GABA. Resp. Br. 47. This is, instead, the classic sort of "internal[] inconsisten[cy]" that constitutes clear error and requires reversal. *Anderson* v. *City of Bessemer City*, 470 U.S. 564, 575 (1985), *quoted in* Resp. Br. 48.

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[8] The study respondents now cite regarding a "linear" increase in midazolam's effect, *see* Resp. Br. 5 n.1, involved administration of midazolam *in conjunction with* the anesthetic drug halothane, and expressly notes that "there may be a ceiling effect of midazolam." Michael A. Melvin et al., *Induction of Anesthesia with Midazolam Decreases Halothane MAC in Humans*, 57 Anesthesiology 238, 240 (1982).

Fourth, respondents try to justify midazolam's constitutionality as the first drug in a lethal-injection protocol by speculating that the ceiling effect may be so high as to be irrelevant here. See Resp. Br. 5–6 n.1, 34. But the study on which respondents rely to show that midazolam's effects increase linearly, and thus, can be used as the sole agent in surgical procedures, actually involved research on the effects of midazolam as an *induction* agent when used *in conjunction with* halothane (an anesthetic). With regard to the ceiling effect, moreover, the researchers noted that "at more than 0.6mg/kg there may be a ceiling effect of midazolam." Melvin, *supra* note 8, at 240. For a 70-kg adult male, that would equate to a ceiling effect after 42 mg of midazolam, which is half the dose administered to Clayton Lockett, and more than ten times less than Oklahoma plans to use in petitioners' executions.

2. Respondents fail to explain why the district court's clear error in crediting Dean Evans's "extrapolation" connecting midazolam's alleged lethality to its ability to reliably cause and maintain a coma does not warrant reversal.

First, there is scant evidence that midazolam can cause death, at any dose. Despite being among the most frequently prescribed medications in the United States, see J.A. 184, petitioners' expert Dr. Lubarsky noted that deaths from midazolam were rare and involved either infirm persons or additional drugs. J.A. 217, 281. Respondents contend that this claim is "undermined by Midazolam's FDA Label, which warns of 'serious and life-threatening cardiorespiratory adverse events' requiring monitoring 'regardless of age or health status.'" Resp. Br. 21; see Resp. Br. 46–47. Respondents ignore the rest of the FDA Label, which is consistent with evidence presented by petitioners:

"[a]dministration of . . . midazolam to elderly and/or high-risk surgical patients has been associated with *rare reports of death* under circumstances compatible with cardiorespiratory depression. *In most of these cases*, the patients also *received other* central nervous system depressants capable of depressing respiration, especially narcotics . ." Midazolam Label 32 (emphasis added); see also *id.* (under "Geriatric Use" warning of "rare reports of death under circumstances compatible with cardiorespiratory depression"). The Label further warns that "[t]he majority of serious adverse effects . . have been reported when midazolam is administered with other medications capable of depressing the central nervous system." *Id.*[9]

Second, even if midazolam can cause death, Dean Evans erred in his calculation of how much midazolam would be needed, mixing up 0.071 mg/kg and 71 mg/kg (a one-thousand-fold difference). See Pet. Br. 36. Respondents rationalize this error as the result of Dean Evans having "inadvertently attached" to his report the wrong data sheet, which itself "contain[ed] an apparent typographical error." Resp. Br. 27 n.16.[10] But on the stand, Dean Evans confirmed that the 71 mg/kg number was correct. J.A. 329. Dean Evans's mistake, no matter the cause, doubly highlights why his testimony was not reliable: if the MSDS could be so in error, that confirms that the MSDS was not a

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[9] Respondents devote significant portions of their brief to impugning Dr. Lubarsky personally, but just as the FDA label directly supports his testimony here about midazolam, so does the medical literature.

[10] Respondents claim that "all parties acknowledge" that preservative-free midazolam "is the midazolam used by Oklahoma." Resp. Br. 27 n.16. Petitioners do not acknowledge, nor do they know, what type of midazolam Oklahoma intends to use in its executions.

reliable source[11]; conversely, if Dean Evans himself knew so little about how much midazolam it takes to kill a person that he could mix up dosages differing by three orders of magnitude, then his testimony is unreliable.

Third, even crediting Dean Evans's testimony and ignoring his mathematical error and unreliable sources, all they show is that some amount of midazolam *might* cause death; they do not prove that it reliably *will* cause death, much less do they establish the extrapolative step that death from a 500 mg dose of midazolam reliably will be preceded by comalike unconsciousness. Indeed, the FDA Label's warnings about the risks of overdose refer to problems with cardio-respiratory depression, not cessation of brain activity. Midazolam Label 32–34. That contrasts starkly with the corresponding warning on pentobarbital's label that, "[i]n extreme overdose, all electrical activity in the brain may cease." Akorn, *Label: Nembutal Sodium Solution*, http://akorn.com/documents/catalog/package_inserts/76478-501-20.pdf (last visited Apr. 20, 2015).[12]

Respondents cannot defend Dean Evans's extrapolation as consistent with basic principles of scientific

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[11] Despite respondents' contentions, it is irrelevant if drugs.com and the MSDS happen to contain correct information. See Resp. Br. 47 n.19. The relevant inquiry is whether those sources "enjoy[] 'general acceptance' within a 'relevant scientific community,'" *Kumho Tire Co.* v. *Carmichael*, 526 U.S. 137, 149–50 (quoting *Daubert* v. *Merrell Dow Pharm.*, 509 U.S. 579, 592–94 (1993)), and they do not.

[12] The defining characteristic of a "coma" is that a person "cannot be aroused, even by powerful stimulation." *Dorland's Illustrated Medical Dictionary* 358 (28th ed. 1994) (definition of "coma"); J.A. 209 ("electrical activity in the brain has stopped"); J.A. 210.

inquiry. Rather, given overwhelming scientific evidence of midazolam's mechanism of action and effects, Dean Evans's opinion was and is indefensible, amounting only to guesswork. Such is not the stuff of reliable expert testimony, nor can it plausibly establish with any degree of reliability midazolam's efficacy for use in a three-drug protocol. See *Anderson*, 470 U.S. at 574.

3. Finally, petitioners did not waive their challenge to the district court's findings of fact or to its reliance on Dean Evans's testimony. Petitioners moved in limine to challenge his expert report, J.A. 35–36, which the district court treated as a "challeng[e to] both Dr. Evans'[s] qualifications and his methodology," J.A. 72, 133. Moreover, both the district court and court of appeals independently assessed Dean Evans's testimony's relevance and reliability. See J.A. 132, 134. Those issues are fully preserved.

Furthermore, even when a failure to raise a *Daubert* challenge does "make it impossible for petitioners to argue that [an expert's] testimony was not 'admissible evidence' under the Rules[,] . it does not make it impossible for them to argue that the evidence [itself] failed" to satisfy the relevant legal standard. *Comcast Corp.*, 133 S. Ct. at 1431 n.4. Petitioners' challenge to findings of fact based on that testimony thus have not been "forfeited." *Id.* The "obvious and exceptional" error of Dean Evans's testimony merits reversal. *Id.* at 1433 n.5.[13]

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[13] If the Court has concerns regarding the factual record, the Court could remand for the district court to conduct further factual proceedings based on this Court's clarification of the proper standard for evaluating what constitutes a constitutionally tolerable level of risk in a lethal-injection protocol.

III. PETITIONERS ARE ENTITLED TO A STAY OF EXECUTION FOR HAVING SHOWN A SIGNIFICANT POSSIBILITY OF SUCCESS ON THE MERITS.

1. The Tenth Circuit misconstrued *Baze* to impose an extra requirement for obtaining a stay that has proved all but insurmountable in this and other cases.

Respondents contend that, because the Tenth Circuit cited *Hill* in discussing the standard for a preliminary injunction, it should not be presumed to have "*sub silentio* substituted that standard" for something more demanding. Resp. Br. 58. Petitioners presume nothing on this point—the court of appeals expressly stated that "the demonstration of a risk of severe pain" was the "first requirement for a stay of execution." J.A. 130; see *Wackerly* v. *Jones*, 398 F. App'x 360, 362 (10th Cir. 2010) (same). Whether the Tenth Circuit viewed *Baze* as displacing the stay standard in *Hill* or as interpreting the meaning of the phrase a "significant probability of success on the merits," the result is the same: The Tenth Circuit interpreted *Baze* to require petitioners to establish that the State's protocol creates a "demonstrated risk" of severe pain, *Baze*, 553 U.S. at 61. This Court should clarify whether it intended to create such a high hurdle for injunctive relief.

2. After assuming that *Baze* created a more demanding stay standard, respondents argue that *Baze*'s express limitation to challenges brought "'on grounds such as those asserted there'" means that "*Baze* applies any time a stay of execution is requested." Resp. Br. 59–60. But it does not follow that *Baze* applies to challenges to *all* methods of execution. Resp. Br. 57–58; J.A. 131. Instead, any uniquely high stay standard emanating from *Baze* should apply on-

ly to those capital cases seeking to improve upon existing safeguards against the "maladministration of a concededly humane [execution] protocol." 553 U.S. at 41, 60–61. Respondents contend that this distinction fails because "the *Baze* petitioners ['hardly'] conceded that the 'State's method, if administered according to plan, would be constitutional.'" Resp. Br. 60. But the *Baze* plurality clearly stated that petitioners "concede[d] that 'if performed properly,' an execution carried out under Kentucky's procedures would be 'humane and constitutional.'" 553 U.S. at 49 (quoting Brief for Petitioners 31).

Where a state's intended method has been found to be constitutional and the only question is whether the state must adopt new safeguards to reduce the risks of harm, a higher stay hurdle is logical. Conversely, a higher stay hurdle does not make sense where, as here, petitioners challenge a drug that is *incapable* of serving as a reliable anesthetic, irrespective of any safeguards. A claim that a state's execution protocol, even if carried out as written, will not be constitutional, warrants a stay once there is "a significant possibility of success on the merits." *Hill*, 547 U.S. at 584 (citing *Barefoot*, 463 U.S. at 895).

IV. THE EIGHTH AMENDMENT DOES NOT REQUIRE PETITIONERS TO REMEDY A STATE'S UNCONSTITUTIONAL ACT.

The Eighth Amendment prohibits certain punishments regardless of whether alternatives are available. Respondents argue, however, that even a cruelly inhumane execution can constitutionally be carried out if petitioners fail to plead and prove an alternative, available method. Otherwise, respondents contend, petitioners are "challeng[ing] the death penalty itself" and leaving Oklahoma "without any alternative to effectuate its laws." Resp. Br. 63. The premises

of this argument are false, and respondents' conclusion should be rejected.

First, petitioners are not challenging lethal injection per se, but just this specific combination of drugs. See J.A. 66–67; Am. Compl. at ¶ 24, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Oct. 31, 2014), ECF No. 75. Petitioners did propose sodium thiopental and pentobarbital as alternatives, *id.* at ¶ 31, and these drugs are still approved in Oklahoma's recently "revamped" protocol. That those drugs may not presently be commercially available to Oklahoma does not mean that petitioners are challenging their death sentences. See *Hill*, 547 U.S. at 582 (permitting claim of cruel and unusual punishment to proceed even though prisoner did not specify an alternative method of execution).

Second, respondents argue that, without a prisoner-selected replacement for midazolam, Oklahoma would be left "without any alternative to effectuate its laws." Resp. Br. 63. But Oklahoma has never argued that it has *no* alternative for carrying out lethal injection available to it, nor did the district court find any such fact. Rather, all the district court found was that two barbiturates, sodium thiopental and pentobarbital were currently "not available to the DOC" for lethal injection. J.A. 127; see also Tr. 296 ("The [State's] vendor . . didn't want to sell [Oklahoma] pentobarbital any longer."). The district court did not have an opportunity to consider that Texas, Georgia, and Missouri have carried out eleven executions using pentobarbital since January.[14] Nor did Oklahoma explain why other states can access pentobarbital

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[14] *See Execution List 2015*, Death Penalty Information Center, http://www.deathpenaltyinfo.org/execution-list-2015 (last visited Apr. 21, 2015).

while Oklahoma's "exhaustive search" has failed to locate the same. Resp. Br. 11. In fact, the letter respondents cite as proof of pentobarbital's unavailability to Oklahoma (which respondents assert was sent by "Oklahoma's supplier of compounded pentobarbital" to the "ODOC," Resp. Br. 11), was actually sent from a *Texas* pharmacy to the *Texas* Department of Corrections in 2013. See Pls.' Opp. to Defs.' Mot. for Protective Order & Br. in Supp. at 16 n.7, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Oct. 21, 2014), ECF No. 68 (citing Notice of Exhibit, *Schad* v. *Brewer*, No. 13-cv-2001-ROS (D. Ariz. Oct. 4, 2013), ECF Nos. 21 & 21-1 (where the letter was publicly filed by the Arizona Department of Corrections)). The letter also is inadequate because Oklahoma has approved four different methods of lethal injection, J.A. 117–18, and because its governor just signed a measure automatically endorsing lethal injection, nitrogen hypoxia, electrocution, or the firing squad, in that order, if any method is ruled unconstitutional *or* becomes unavailable. See 2015 Okla. Sess. Laws Ch. 75 (H.B. 1879).

Third, respondents argue that the lack of alternatives, when caused by "the decisions of third parties," makes it "logical and necessary" for the State to use whatever methods it has at its disposal. Resp. Br. 63–64. Although "capital punishment is constitutional," *Baze*, 553 U.S. at 47, that precept does not require this Court to condone *any* method of execution—much less one as painful as the one under review here—simply because Oklahoma reports that it has run out of methods other than the one under review. The Bill of Rights' guarantees are not diminished even by true emergencies, *Ex parte Milligan*, 71 U.S. 2, 120 (1866) (holding that wartime closure of courts did not permit abrogation of Sixth Amendment

rights), much less by Oklahoma-specific supply shortages. If the particular three-drug protocol at issue here is ruled unconstitutional, then Oklahoma will find another protocol, as it has in the past. See Resp. Br. 9–14.

Fourth, respondents offer no justification for why, if the State lacks other options, prisoners must articulate the remedy for the State's constitutional missteps. Such a requirement is unprecedented in Eighth Amendment jurisprudence, see, *e.g.*, *Trop* v. *Dulles*, 356 U.S. 86, 103 (1958) (plurality opinion); *Weems* v. *United States*, 217 U.S. 349, 382 (1910); a proposition that respondents do not even attempt to refute. It is also illogical, in that petitioners cannot know the availability to Oklahoma of particular drugs because Oklahoma keeps the identity of its pharmaceutical sources confidential. Any such rule, moreover, would restrict rather than respect state sovereignty, because a prisoner-proposed alternative might conflict with the State's legislatively authorized set of backup execution methods, see *supra* p. 19, which would lead to federalism concerns not present if the State were free to construct its own constitutional means of carrying out death sentences. See *Rizzo* v. *Goode*, 423 U.S. 362, 379–80 (1976).

Finally, respondents contend that *Hill* v. *McDonough* merely clarified pleading standards for § 1983 claims raising Eighth Amendment issues, and did not speak to the elements of an Eighth Amendment claim. Resp. Br. 58. That argument is not tenable. The Court "unanimously rejected a proposal that § 1983 suits challenging a method of execution must identify an acceptable alternative." *Jones* v. *Bock*, 549 U.S. 199, 213 (2007) (construing *Hill*, 547 U.S. at 581–82). The core issue in *Hill* was whether an Eighth Amendment plaintiff had to plead an alterna-

tive; in holding that he need not, the Court made no distinction between what must be pleaded and what must be proven, nor between the elements of a § 1983 claim and the underlying Eighth Amendment right. Nor would such a distinction make sense, given that any similar Eighth Amendment challenge would arise virtually only in the context of a § 1983 claim. Moreover, even if *Baze* and *Hill* had "addressed two entirely separate questions," Resp. Br. 65–66, construing *Baze* as respondents suggest would all but vitiate *Hill*'s holding, which this Court does not ordinarily do *sub silentio*. See *Shalala* v. *Ill. Council on Long Term Care, Inc.*, 529 U.S. 1, 18 (2000).

CONCLUSION

For the foregoing reasons and those stated in our opening brief, the judgment of the court of appeals should be reversed.

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